

**Meeting of the
Medicaid Revitalization Committee
August 9, 2006**

Members Present:

Leslie C. Ellwood, M.D., Medical Society of Virginia
/Virginia Academy of Pediatrics
Rose Chu, Board of Medical Assistance
Doug Gray, Medicaid MCO Representative
Mary Ann Bergeron, Virginia Association of
Community Service Boards
Sheryl Garland, Virginia Commonwealth University
Marcia Tetterton, Virginia Association of Homecare
Joanne Green for Judith Cash, Virginia Healthcare
Foundation
Maureen Hollowell, Persons with Disabilities
Jill Hanken, Virginia Poverty Law Center
Bill Farrington for Alexander Macaulay, National
Alliance on Mental Illness
Hobart Harvey, Virginia Health Care Association
Chris Bailey, Virginia Hospital and Healthcare
Association
Diana Wallace, Virginia Association of Area
Agencies on Aging
Rebecca Snead, Virginia Pharmacists Association

DMAS Staff:

Patrick Finnerty, Agency Director
Cynthia B. Jones, Chief Deputy Director
Cheryl Roberts, Deputy Director of Programs & Operations
Steve Ford, Director, Policy & Research Division
Gerald Craver, Policy Analyst, Policy & Research Division
John Kenyon, Policy Analyst, Policy & Research Division
Scott Cannady, Policy Analyst, Policy & Research Division

Guest Panel Members:

Shannon Stepp, Health Management Corporation
Alycia Sepe, Health Management Corporation
Megan Padden, Sentara Health Plans

Meeting Facilitator:

Barbara Hulburt

I. Welcome and Overview of Agenda by Pat Finnerty, Director of DMAS

Mr. Finnerty began by welcoming everyone to the Medicaid Revitalization Committee (MRC) meeting.

Mr. Finnerty reviewed the agenda for the meeting, indicating to members that the discussion of the optional provisions of the Federal Deficit Reduction Act (DRA) had been postponed to a future meeting due to time limitations.

II. Approval of the August 2nd Meeting Minutes

The minutes of the August 2nd Committee meeting were approved by the MRC.

III. Continuation of Electronic Access Discussion

Mr. Finnerty provided the Committee members with a summary of the August 2nd meeting discussion on electronic access to the Medicaid program and offered three “discussion points” for the Committee to consider in its report to the General Assembly. Mr. Finnerty made it clear to the Committee members that these discussion points were offered only to further the Committee’s deliberations, and were not designed to limit any other discussion or possible recommendations by the Committee related to this topic.

After presenting these options, Barbara Hulburt facilitated the Committee's discussion. The Committee discussed how best to encourage providers to participate in electronic options in regard to Medicaid claims submittal and payment. After comments and suggestions were provided by Committee members, Ms. Hulburt summarized the Committee's consensus on the discussion points as follows:

1. DMAS should mandate the use of Electronic Funds Transfer for all providers in order to receive payment, including providers paid through participating Managed Care Organizations.
2. DMAS should "encourage" providers, both in Managed Care and in the fee-for-service program to submit claims electronically and revisit the issue of mandating electronic claims submission after marketing and training efforts to expand electronic claims submissions has been completed.
3. DMAS should move forward with the development of a web-based electronic claims submission system and should provide training and technical assistance to providers for this system once implemented. This technology should also be available to providers participating with Managed Care Organizations in the Medicaid program.

There was considerable discussion regarding the potential to incentivise providers financially, beyond the inherent efficiencies, for participating in electronic claims submittal and electronic funds transfer. However, consensus was not reached in terms of whether the Department should provide such direct financial incentives and what priority such an approach would have relative to other potential recommendations of the Committee.

After this discussion, Mr. Finnerty informed members of the contents of their packet, which included the following material:

1. Per member, per month payment to Disease Management Contractor
2. Disease Management and Virginia's Medicaid program – 2006 Report to the General Assembly
3. *Healthy Returns* disease management report – Health Management Corporation (HMC)
4. DMAS' measures for evaluating the Disease Management Program
5. *Healthy Returns* Disease Management Program Status Report
6. Overview of State Managed Care Programs
7. Virginia Managed Care Performance Report, 2004-2005

All meeting documents are available on the Medicaid Revitalization Committee's website at: http://www.dmas.virginia.gov/ab-revitalization_home.htm.

Mr. Finnerty also mentioned that a company had presented information to DMAS staff on its web-based claims submission product that he thought may be helpful to the Committee members. DMAS staff provided copies of this presentation to the Committee members.

IV. Continuation of Disease Management Discussion

Mr. Finnerty began the panel discussion by introducing the speakers and then reviewing the Disease Management (DM) discussion from the prior meeting.

Following that discussion, Megan Padden of Sentara Health Plans, representing the Medicaid managed care organizations participating in Medallion II, presented information regarding Sentara's approach to DM in the Medicaid program. Alycia Sepe then provided a presentation to the committee on Health Management Corporation's DM program for the Medicaid fee-for-service (FFS) program.

After these two presentations, Mr. Finnerty introduced four discussion points for the Committee's consideration regarding DM. Mr. Finnerty again reiterated to the Committee members that these discussion points were offered only to further the Committee's deliberations, and were not designed to limit any other discussion or possible recommendations by the Committee related to this topic.

After these discussion points were offered, Ms. Hulburt proceeded to facilitate the discussion of the Committee members. There was considerable discussion of which disease states should be addressed by the Medicaid program. The Committee appeared to focus on the notion that any DM program expansion should include high prevalence diseases for which there are significant and on-going healthcare costs associated with the condition, and for which nationally-accepted care guidelines could be utilized in the DM program.

Additionally, the notion of combining aspects of the current patient-centered DM approach with active participation of a healthcare provider was discussed and appeared to be well-received by the Committee. The discussion of the inclusion of financial incentives for provider participation in the DM programs was mixed, with some Committee members indicating that improvement in overall payment levels may hold a greater priority than an incentive approach. Committee members indicated that instead of doing all aspects of an expanded DM program statewide, the Committee may wish to consider advising DMAS to focus efforts in one or more pilot programs.

There was additional follow-up discussion regarding the idea of provider payments for episodes of care. Committee member Chris Bailey provided an overview of PROMETEUS, which represents a payment approach utilizing an evidence-based case rate encompassing all provider types involved in an episode of care.

Finally, the Committee appeared to embrace the idea of utilizing an enhanced benefit approach, or similar mechanism, to reward adherence to care plans and healthy behaviors generally. However, there was significant discussion regarding how such a program should be set up (the types of goods and services allowable for purchase through these incentives and the measurement of healthy behaviors that would generate rewards).

Throughout the DM program discussion, the Committee also deliberated on the extent to which the Managed Care Plans should be required to, at a minimum, offer all of the same DM program aspects to recipients and providers participating in the Medallion II program.

After comments and suggestions were provided by Committee members, Ms. Hulburt summarized the committee's consensus on the discussion points as follows:

1. Seek funding and approval for a "holistic" DM model that includes both a "provider centric" and "patient centric" approach.
2. Focus not only on cost savings, but efficiencies and quality measures in any DM program.
3. Consider the development of "pilot programs" for specific disease states and/or incentive programs.
4. Include ongoing educational and technical assistance for both providers and clients as a part of any DM Program.
5. Consider the following disease states, in addition to the existing disease states currently in the existing program, for future DM programs:
 - a. COPD
 - b. Anxiety/Depressive Disorders
 - c. Sickle Cell Anemia
 - d. Other Mental Health Issues
 - e. Maternity
6. Include expanded DM programs in both fee-for-service and Managed Care.

The Committee discussed that many of the recommendations would have added costs (at least initially) for implementation in the Medicaid program. There were concerns that any new programs/initiatives implemented should be implemented with new funding and not cause existing items, such as payment rates or eligibility criteria, to be artificially restricted or lose ground. As such, the Committee recognized a need to prioritize the recommendations of the group at some point in the report drafting process.

V. Medicaid Managed Care

This agenda item was postponed to the next MRC meeting due to insufficient time remaining to cover the topic

VI. Additional Committee Discussion

The Committee agreed to expand the time of the next meeting (August 29) in order to cover additional material that the Committee has to date been unable to discuss due to time constraints.

VII. Adjourn

The meeting was adjourned at approximately 12pm.